REMARKS

By this amendment, claims 1-2, 8, and 55 have been amended, claims 3, 7, 9 and 16-17 remain unamended, new claims 59-64 have been added, and no claims have been deleted. Hence, claims 1-3, 7-9, 16-17 and 55, and 59-64 remain currently pending.

1. Response to Claim Rejections under 35 U.S.C. § 112

Claims 1-3, 7-9, 16-17, and 55 are rejected under 35 U.S.C. § 112, first paragraph, as containing subject matter which was not described in the specification. The Office Action states that the claim element of "a targeted monetary incentive" as disclosed in claims 1 and 55 is not supported by the original disclosure. (Office Action, 06/15/2007, p. 3). Although applicants disagree with the assertion that this claim element constitutes new matter to the original disclosure, applicants have hereby amended claims 1 and 55 to remove the word "targeted." It is respectfully submitted that in light of this amendment, the instant rejection of the claims under 35 U.S.C. § 112 is rendered moot. It is further respectfully submitted that the added claim element of "representing the cost savings as an incentive payment that is to be apportioned among the responsible provider" is present in the original disclosure, such as on page 10 of the specification, which states that "the resulting savings is then split between provider 20, payer 30, and incentive administrator 40."

2. Response to Claim Rejections under 35 U.S.C. § 103

Claims 1-3, 7, 16, and 55 are rejected under 35 U.S.C. § 103(a) as being unpatentable over Kessler et al., U.S. Patent Number 5,324,077 (hereinafter "Kessler") in view of Bitran, et al, Provider Incentives and Productive Efficiency in Government Health Services document, September , 1992. URL: http://www.phrplus.org/Pubs/hfsmar1.pdf (hereinafter "Bitran"), and further in view of Seare, U.S. Patent Number 5,557,514 (hereinafter "Seare"), and Boyden article, "The appropriate use of financial incentives to encourage preventative care in general practice," May 2000 (hereinafter "Boyden").

Claim 1 (with emphasis added below) presently recites:

1. A computer-implemented method, executed in a first computer operated by an incentive administrator that is coupled to a second computer operated by a payer and a third computer operated by a healthcare provider, of providing an apportioned monetary incentive upon completion of a course of treatment for a patient with a condition during an episode of care, the method comprising the steps of:

identifying a responsible provider from among one or more healthcare providers involved in the course of treatment, based on performance of a defining procedure in the course of treatment;

creating an initial baseline value related to the course of treatment;

receiving over the computer network from the payer, a diagnosis of the patient performed by a healthcare provider and provided to the payer, along with an associated cost quantified by the initial baseline value;

creating an episode of care based upon the diagnosis of the healthcare provider and the course of treatment for the condition;

verifying that the episode of care is not an outlier case representing an extreme condition that costs significantly more than the cost associated with the initial baseline value;

summing a plurality of claims processed during the episode of care to obtain a total treatment cost;

adjusting the initial baseline value by factoring in any effects due to comorbidity to derive an adjusted baseline value;

determining if the total treatment cost is less than the adjusted baseline value, thus resulting in a cost savings for the decided course of treatment;

representing the cost savings as an incentive payment that is to be apportioned among the responsible provider, the payer and the incentive administrator;

causing a first portion of the cost savings to be sent to the responsible provider in the form of a monetary incentive that is individually calculated based on the episode of care, and correlated to the total treatment cost;

causing a second portion of the cost savings to be sent to the payer, the second portion constituting a savings in the amount paid out for the course of treatment; and

causing a third portion of the cost savings to be retained by the incentive administrator, wherein the responsible provider, the payer, and the incentive administrator are independent entities.

As stated in the instant Office Action, "Kessler, Bitran and Seare teach sending monetary incentives to healthcare providers to keep 'actual costs' below the baseline," but that "the combined art fails to explicitly disclose a targeted incentive." (Office Action, 06/15/2007, p. 8). However, the Examiner cites Boyden as teaching this element.

As a preliminary matter, it is respectfully submitted that Boyden does not qualify as prior art because applicant's date of invention precedes the publication date of Boyden. To

qualify as prior invention under 35 U.S.C. § 103, Boyden must have been published before applicant's invention of the claimed invention. The applicant's date of invention is presumed to be the date on which the present application was filed unless shown otherwise pursuant to 37 C.F.R. § 1.131. Applicant's herewith submit an affidavit of showing prior inventorship under 37 CFR § 1.131. It is respectfully submitted that the showing of facts made by this affidavit is such, in character and weight, as to establish conception and reduction to practice prior to the publication date of Boyden. Consequently, it is respectfully submitted that Boyden does not qualify as prior art under 35 U.S.C. § 103, and that the independent claims 1 and 55, and their respective dependent claims are not rendered unpatentable by the cited combination.

Assuming, *arguendo*, that Boyden does qualify as prior art, applicant respectfully submits that claim 1, as amended is sufficiently distinguishable over any current and previously cited references, including Boyden. Independent claims 1 and 55 have been amended to recite a method of providing an apportioned monetary incentive by determining a baseline value for a course of treatment, identifying a responsible provider, obtaining a total treatment cost incurred by a responsible provider, and determining what savings, if any, is available as an apportioned incentive, and then "causing a first portion of the cost savings to be sent to the responsible provider in the form of a monetary incentive that is individually calculated based on the episode of care, and correlated to the total treatment cost; causing a second portion of the cost savings to be sent to the payer an constituting a savings in the amount paid out for the course of treatment; and causing a third portion of the cost savings to be retained by the incentive administrator," in a system in which the payer, provider, and incentive administrator are independent entities.

Although some of the cited prior art references may mention the use and value of incentives in the healthcare industry, none teach or suggest the determination of an apportioned incentive derived from savings relative to a baseline value for a course of treatment, and that is apportioned among a responsible provider, a payer, and an incentive administrator, who are independent entities from one another. These references speak generally about the use of incentive payments to affect the treatment of patients, but none teach or suggest the use of an independent incentive administrator and the apportionment of

cost savings among the provider, payer, and incentive administrator as claimed in amended claims 1 and 55. The claimed invention provides a system in which the responsible provider, as a decision maker, is encouraged to reduce costs and provide more cost-effective service because the cost savings that gives rise to the apportioned incentive is directly tied to his or her performance relative to a baseline for the course of treatment. The apportionment of cost savings among the payer, responsible provider, and incentive administrator, as claimed, eliminates much of the conflict of interest problems that are associated with present healthcare management systems in which a payer (insurer) and physician together, and without the presence of an independent incentive administrator, may simply decide to withhold medical services to cut costs. Indeed, this present insurance payment model (e.g., HMO or PPO) which is pervasive in today's medical industry, has been blamed for the marked decrease in the quality of medical care in recent years.

To the extent that any of the present cited references discuss incentives, they do so within present industry systems in which there is no independent incentive administrator or model in which total costs for a course of treatment are calculated, compared to a baseline, and then provided to a responsible physician as part of an apportioned incentive. None of the cited references, either together or separately, teach or suggest the distribution of an apportioned incentive among the three independent entities of the provider, payer, and incentive administrator. Indeed, the lack of any such teaching or suggestion only serves to underscore the novelty of invention claimed in the present application, and belies any argument that such elements are well known in the art.

Therefore, in light of the amendment to claim 1, it is respectfully submitted that claim 1 and its dependent claims, 2-3, 7-9, 16-17, and 59-64 are patentable under 35 U.S.C. § 103 in view of the cited references.

Independent claim 55 has been amended to include elements similar to amended claim 1. For the reasons provided above with respect to claim 1, it is respectfully submitted that claim 55 is patentable under 35 U.S.C. § 103 in view of the cited references.

3. Petition for Extension of Time

A Petition for Extension of Time Under 37 CFR §1.136(a) is enclosed herewith for a

three-month extension of time.

Applicants respectfully request that this response and accompanying Declaration and papers be made part of the official record in the present application. If there are any shortages, the Examiner is authorized to charge our Deposit Account Number 503616.

Respectfully submitted,

COURTNEY STANIFORD & GREGORY LLP

Dated: December 14, 2007

By: _____

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